

HIV/AIDS Action Plan

Sexual and Reproductive
Health Strategy

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Foreword

As the world enters the third decade of the AIDS epidemic it is timely to review and up date our response to HIV/AIDS in New Zealand. The need for this was signalled in phase one of the Sexual and Reproductive Health Strategy released in 2001. New Zealand has been relatively successful in containing the HIV/AIDS epidemic, but that is no reason for complacency. In this third decade we are seeing the devastating effect HIV/AIDS can have on a country's economic and social fabric if they are not contained. As a country with a relatively small population New Zealand is vulnerable.

In 2002, 107 people were newly diagnosed with HIV in New Zealand. That is the highest number for over a decade. While it is too early to tell whether this represents a trend, many developed countries also experienced a jump in HIV-positive diagnoses in 2002. Around the world an estimated 5 million people became infected with HIV (and an estimated 3.1 million died of AIDS in 2002) bringing to 42 million the estimated number of people globally living with the virus. In this age of international travel New Zealand's physical isolation is not a protection.

New Zealand must sustain a long-term public health approach to the HIV epidemic that puts primary prevention at its centre. We must maintain and strengthen our efforts to reduce the risk, vulnerability and impact of the epidemic on the communities most at risk of HIV infection. Governments must continue to ensure they provide strong leadership in the management of the epidemic. We must strengthen and build on our partnerships with the community-based organisations that are best placed to improve the sexual and reproductive health outcomes of the communities with which they work.

This HIV/AIDS action plan sets out a comprehensive set of actions that together should ensure we provide a comprehensive and effective response to HIV/AIDS in New Zealand. Many of the actions are already in place and they need to be continued and, in some





cases, could be strengthened or extended. Some new directions are also indicated to meet the immediate and medium-term challenges we are facing. As well as providing guidance on actions, this action plan provides information on HIV/AIDS epidemiology, the groups most affected, implications for other groups in New Zealand society and international best practice in combating the epidemic.

While we have been successful in our efforts to contain the epidemic in New Zealand, where HIV is concerned we cannot afford to let our guard down. We must maintain and strengthen our efforts to combat this disease because although there is no cure and no biological vaccine, prevention is entirely possible.

Hon Annette King
Minister of Health





Introduction

In 2001 phase one of the Sexual and Reproductive Health Strategy was released. It provided the overall vision, principles, obligations, strategic context and strategic directions for achieving the vision of good sexual and reproductive health for all New Zealanders. At that time it was signalled that in phase two more detailed action plans would be developed in specific areas, including HIV/AIDS. This HIV/AIDS action plan and the 2003 publication, *Sexual and Reproductive Health: A resource book for health care organisations*, together comprise phase two of the Sexual and Reproductive Health Strategy. Overall, phases one and two of this strategy should assist in achieving the goal of healthy New Zealanders.

Why have an HIV/AIDS action plan?

It is important to review and update periodically New Zealand's response to the HIV/AIDS epidemic. In addition, recent changes in the characteristics of people infected with HIV in New Zealand require a re-evaluation of our strategies.

New Zealand is a signatory to international agreements in which governments commit to action and leadership in combating HIV/AIDS. Key goals, from the International Conference on Population and Development (ICPD) and the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) in 2001, (which adopted the Declaration of Commitment on HIV/AIDS), that are of relevance to the New Zealand context include:

- ensuring guidelines for HIV treatment and care provide for the wide provision of, and access to, voluntary HIV testing, counselling services and condoms (ICPD)
- promoting informed, responsible and safer sexual behaviour and practices (ICPD)
- reducing the proportion of infants infected with HIV by 20 percent by 2005 and by 50 percent by 2010, by ensuring that 80 percent of pregnant women accessing antenatal care have information, counselling and other HIV prevention services available to them (UNGASS)
- ensuring that by 2005 at least 90 percent and by 2010 at least 95 percent of people aged 15 to 24 have access to the information, services and education, including peer education and youth-specific HIV education, necessary for them to develop life skills to reduce their vulnerability to HIV infection, and working in full partnership with youth, parents, families, educators and health-care providers (UNGASS)





- developing, by 2003, national strategies to strengthen health care systems and address factors affecting the provision of HIV-related drugs, for example affordability and pricing (UNGASS)
- enacting, strengthening or enforcing, as appropriate, by 2003 legislative and other measures to eliminate all forms of discrimination against, and ensuring the full enjoyment of human rights and fundamental freedoms by, people living with, and vulnerable to, HIV/AIDS.

Combating HIV/AIDS is also one of the millennium development goals affirmed by United Nations member states at the United Nations September 2000 Millennium Summit.

How this plan was developed

The Ministry of Health developed this HIV/AIDS action plan with the assistance of a sector reference group. The sector reference group included HIV/AIDS specialists, representation from the New Zealand AIDS Epidemiology Group, non-governmental organisations providing sexual and reproductive health services, and the organisations the Ministry of Health contracts to provide services to the populations in New Zealand most vulnerable to HIV infection. The members are listed in the Appendix.

The Ministry of Health used the New Zealand AIDS Foundation document *The New Zealand HIV/AIDS Strategy 2002–2006* (2002) as the starting point for developing the first draft of this HIV/AIDS action plan. This HIV/AIDS action plan is the last of many iterations of the original draft HIV/AIDS action plan commented on by the sector reference group. The members

of the sector reference group have provided often-detailed comments on each iteration of the plan.

The process of drafting, revising and commenting on the HIV/AIDS action plan has been a long one and the Ministry of Health wishes to acknowledge the considerable amount of time and effort made by sector reference group members.

What are HIV and AIDS?

HIV (human immunodeficiency virus) is a virus that causes a lifelong infection that damages the body's immune system. AIDS (acquired immune deficiency syndrome) is a late consequence of HIV infection. Without specific treatment AIDS-defining conditions (serious infections or cancers indicating a severely damaged immune system) occur on average about 10 years after a person becomes infected with HIV. However, the time from HIV infection to development of AIDS may range from a few months to more than 20 years. Treatment extends the period before an HIV-positive person develops AIDS and may keep people well indefinitely. However, HIV can develop resistance to one or more treatments as a result of continual mutation and this resistance can result in treatment failure (Grierson et al 2002).

HIV is transmitted through the exchange of body fluids such as blood and semen. Worldwide HIV has most commonly been transmitted by:

- anal intercourse without a condom (both partners are at risk)
- vaginal intercourse without a condom (both partners are at risk)



- shared drug injecting equipment
- an infected mother to her baby during pregnancy, at child birth, or by breastfeeding.

HIV has less commonly been transmitted by:

- vaginal or anal intercourse with proper use of a condom
- oral sex without a condom (ejaculation increases the risk)
- fresh blood-contaminated sharp injuries or splashes, for example needle-stick injuries for health workers. The reason why HIV is rarely transmitted in this manner is because there are relatively few needle stick injuries involving HIV-positive people in New Zealand. The per episode risk for needle stick injuries is similar to the per episode risk for vaginal intercourse without a condom (Royce et al 1997).

In New Zealand, infection with HIV as a result of a transfusion of blood or blood products is unlikely because of the comprehensive screening and testing procedures in place. Serologic testing for HIV infection in blood donors began in September 1985.

There is no evidence that HIV has ever been transmitted by: cuddling; massage; shaking hands; sharing knives, forks, cups or glasses; toilet seats; swimming pools or mosquito bites.

Trends in HIV epidemiology in New Zealand

Data on HIV epidemiology is more useful than AIDS data for monitoring trends in the epidemic, health planning, programme development and evaluation. For monitoring current HIV transmission, the reporting of AIDS cases is of limited value because of the usually

long delay (median about 10 years) between infection with HIV and the development of AIDS. In monitoring HIV epidemiology, it is important to identify the populations affected and the behaviours that put them at risk. As well as national population data it is important in New Zealand to monitor the incidence of HIV among men who have sex with men (MSM), refugees and migrants from high-prevalence countries, injecting drug users (IDUs), and sex workers.

Under the Health Act 1956, it is not mandatory to report people who have tested positive for HIV.¹ Since testing became available in 1985 the laboratories performing the diagnostic tests have provided anonymous information on the number of positive tests and the likely mode of infection. By the end of 2002, 1665 people have been reported to the New Zealand AIDS Epidemiology Group (the Group) through diagnostic testing. Since the beginning of 1996 the Group has sought further epidemiological information from all clinicians who have requested the test. This information includes the tested person's age, sex, ethnicity and likely mode of infection. From 2002 information has also been received from the four New Zealand laboratories performing HIV viral load tests. This allows data to be cross-checked to ensure all those living in New Zealand and diagnosed with HIV are included on the HIV database. By the end of 2002, a further 222 people have been reported to the Group through viral load testing, bringing the total number of people reported to be HIV-positive to 1887.

¹ Public health legislation including the schedules of notifiable diseases is under review.





There are two important points to note in relation to HIV epidemiology. First, it is not possible to tell from HIV laboratory testing information when the infection was acquired. This means the incidence of new HIV infections by year cannot be calculated as this requires knowing the year when viral transmission occurred; HIV infection may have happened some years before the diagnosis. It is possible to determine the period within which HIV was contracted only if the person has had a prior negative HIV test. From 1 January 1996 to 31 December 2002, only around 30 percent of people diagnosed with HIV in New Zealand had had a previous negative HIV test.

Secondly, the data relate only to those people who have been diagnosed with HIV. Overseas research estimated that around a third of people infected with HIV were unaware of their infection (Rogers et al 2002), with the proportion who were unaware of their infection rising to 70 percent among some gay men (Dodds et al 2002; MacKellar et al 2002). It is not known whether this is the case in New Zealand.

People who are unaware they are HIV positive pose a risk of unwittingly transmitting HIV. A person can be HIV positive, but still look and feel healthy for many years. Treating HIV reduces the concentration of HIV in the blood and body fluids, thereby reducing the risk of transmission during unprotected sex or other risky activities. People who are unaware they are HIV positive and who feel and look healthy, may be more inclined to risk unprotected sex with a partner they believe is also HIV negative.

In terms of HIV prevention, it is important to maintain primary prevention strategies to limit new cases of HIV infection occurring, rather than relying on secondary prevention approaches of diagnosing and treating people

already infected with HIV. In the case of HIV, this means using condoms during anal and vaginal sex and using sterilised needles and syringes for drug injecting, as well as the more fundamental safer sex practices, such as having fewer casual sex partners, and less injecting drug use. Services that provide voluntary counselling and HIV testing can advise people about HIV prevention measures to ensure HIV-negative individuals remain negative and HIV-positive individuals have access to treatment and care services.

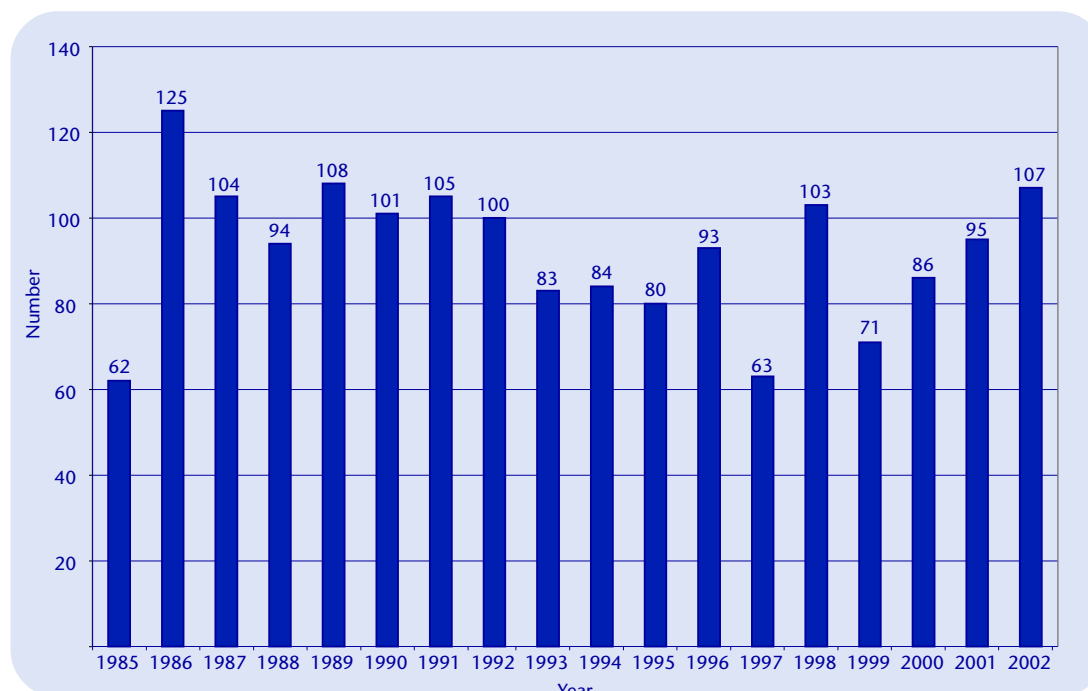
Over the last 15 years the number of people diagnosed each year with HIV has been greater than the number dying from AIDS. Although some people with HIV will no longer be in the country, it is likely there has been a steadily increasing number of people in New Zealand with diagnosed HIV who require care. A study of New Zealand's HIV-positive population concluded that at the end of 2000 approximately 800 HIV-positive people were under active care (Mills et al 2002).

The number of men (1608) reported with HIV since 1985 is significantly more than the number of women (261), but more recently women are making up a greater proportion of the annual numbers diagnosed.² This reflects trends in other developed countries, such as France and Spain. From 1985 to 1995 women's share of the annual newly diagnosed HIV population rose from 12 percent to 20 percent in France and from 7 percent to 19 percent in Spain (UNAIDS 1999). However, the epidemiology of HIV is different in these countries as there are many more injecting drug users infected with HIV.

² In 18 cases, sex was not stated.



Figure 1: Annual total numbers of people newly diagnosed with HIV infection in New Zealand, 1985–2002



Source: New Zealand AIDS Epidemiology Group

Figure 1 shows how the annual total numbers of people newly diagnosed HIV-positive has fluctuated since reporting began in 1985. There were 107 people newly diagnosed with HIV infection in 2002. This is the highest number since 1989. This emphasises the need for ongoing prevention programmes.

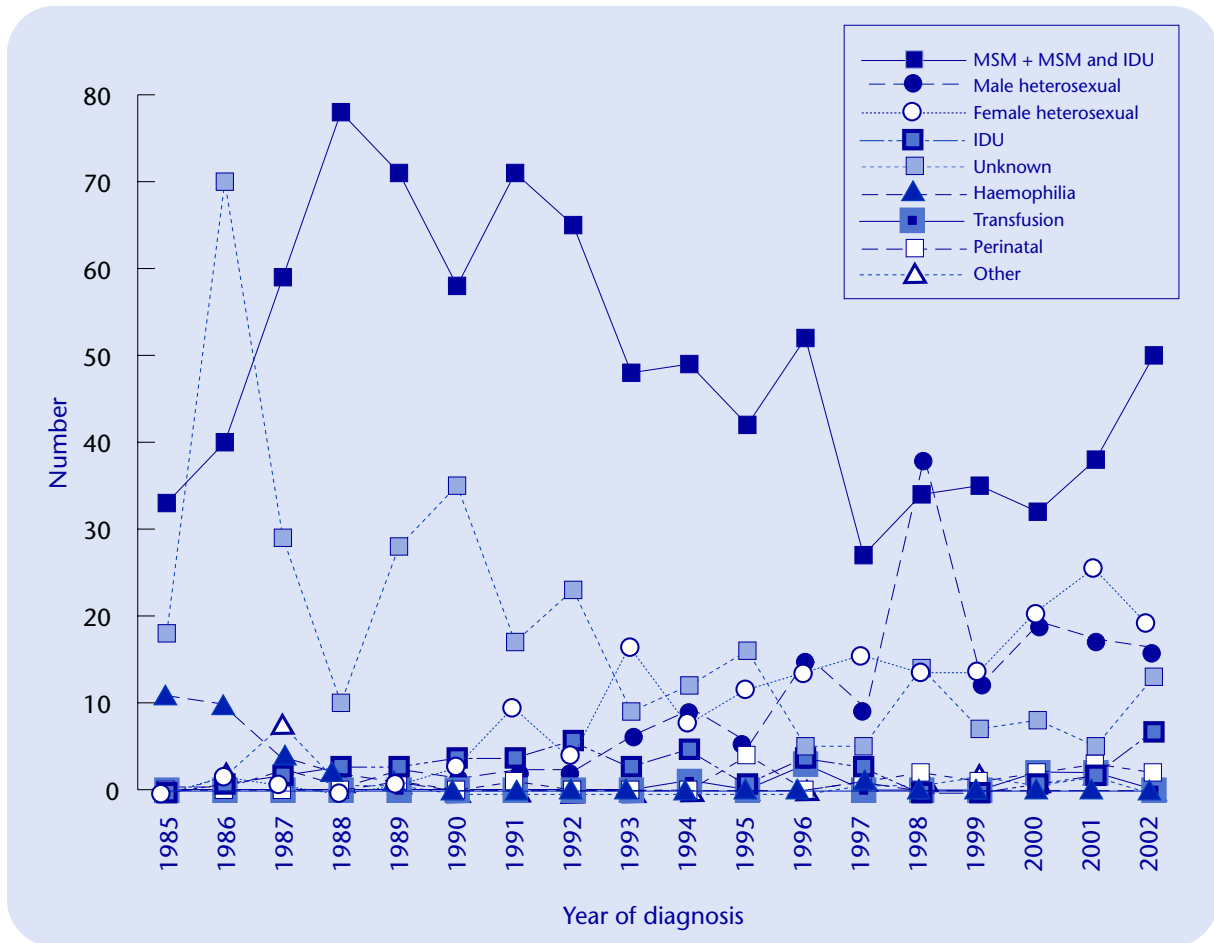
Figure 2 shows the changes in the likely mode of HIV transmission of people found to be HIV-positive since 1985. Early in the epidemic more than 80 percent of people found to be infected with HIV were men who have sex with men (MSM). After several years when relatively few MSM were diagnosed with HIV, the number rose in 2002. In 2002 infection through heterosexual contact accounted for around a third of newly diagnosed HIV infections

compared with 6 percent of newly diagnosed HIV infections in 1992. A factor that contributed to the peak in newly diagnosed males with heterosexually acquired HIV infections in 1998 was the large number of refugees (41) diagnosed with HIV infection through the refugee health assessment in that year. Since reporting on HIV diagnosis as part of the refugee health assessment began in 1994, 107 refugees have been diagnosed, which is about 14 percent of the total number (782) of people diagnosed between 1994 and 2002. Injecting drug use as a mode of transmission has maintained a low incidence, indicating that harm minimisation strategies, including the needle and syringe exchange programme, have been successful, but clearly need to continue.





Figure 2: Number of people newly diagnosed with HIV infection by year of diagnosis and likely mode of infection, New Zealand, 1985–2002



Source: New Zealand AIDS Epidemiology Group

From 1996 to 2002, 618 people were reported to the New Zealand AIDS Epidemiology Group through HIV diagnostic testing and 222 people through viral load testing. Of these 840 people, it appears 51 percent acquired their HIV infection through man to man unprotected anal sex (hereafter referred to as homosexual contact) and 34 percent through male to female unprotected vaginal sex (hereafter referred to as heterosexual contact). Nearly three-quarters of the heterosexually acquired HIV infections were as a result of unprotected sex in, or with a person from, a high-prevalence area. Eight percent of the heterosexually acquired HIV

infections were as a result of unprotected sex with a high-risk partner.³

HIV acquired through heterosexual transmission was more likely to have been acquired overseas than in New Zealand. People with heterosexually acquired HIV infection were far more likely to have acquired their infection in Africa (43 percent) or in the South-East Asia region (26 percent) than men with homosexually acquired HIV infection

³ The high-risk partner category refers to partners who are either men who have sex with men and women (MSMW), intravenous drug users (IDUs) and/or have haemophilia or a coagulation disorder.



(1 percent and 5 percent respectively). Just over a fifth of men with homosexually acquired HIV infection acquired their infection in Australia compared with 2 percent of people with heterosexually acquired HIV.

Unprotected anal sex between men continues to be the highest risk behaviour for HIV transmission in New Zealand. Just over half the men with homosexually acquired HIV infection acquired their infection in New Zealand compared with 18 percent of people with heterosexually acquired HIV infection.

Figures 3, 4 and 5 show the age, ethnic and regional distribution of the diagnosed HIV-

positive population. Age data have been collected since reporting of new HIV diagnoses began, but since 1996 more precise ethnicity and usual residence data have also been collected. This is why the totals in Figure 3 differ from those in Figures 4 and 5.

The majority of people diagnosed with HIV are clustered in the 20–49 age group. However, the patterns for men and women differ. In men, higher numbers of positive tests were found in the 30–39 age group followed by the 20–29 age group; in women, the 20–29 age group had the highest number of positive tests, followed by the 30–39 age group.

Figure 3: Age at time of HIV diagnosis (n=1665)

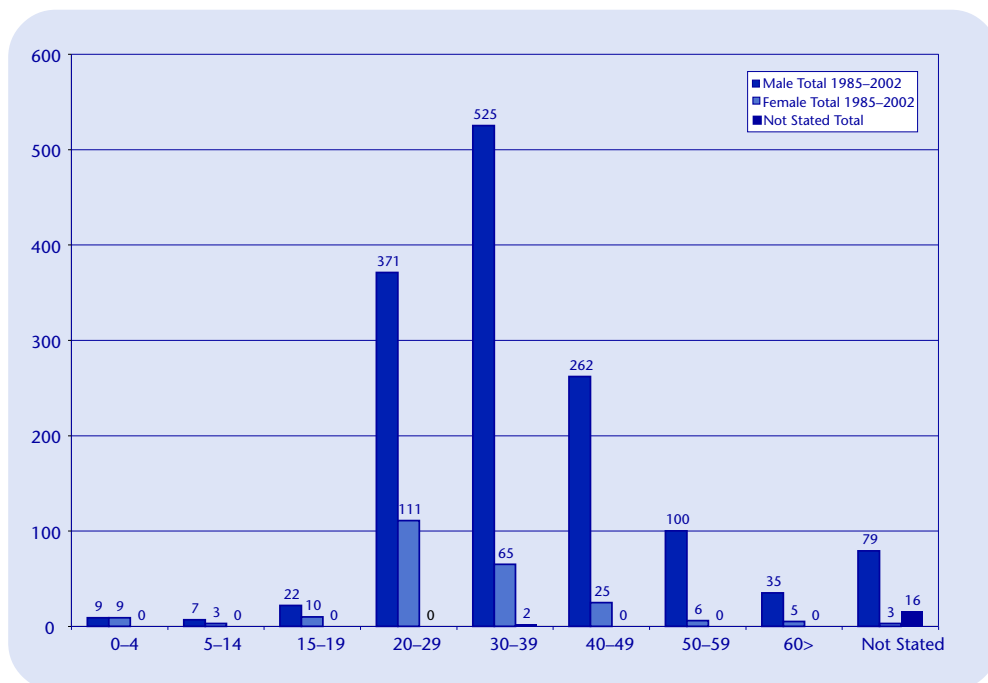
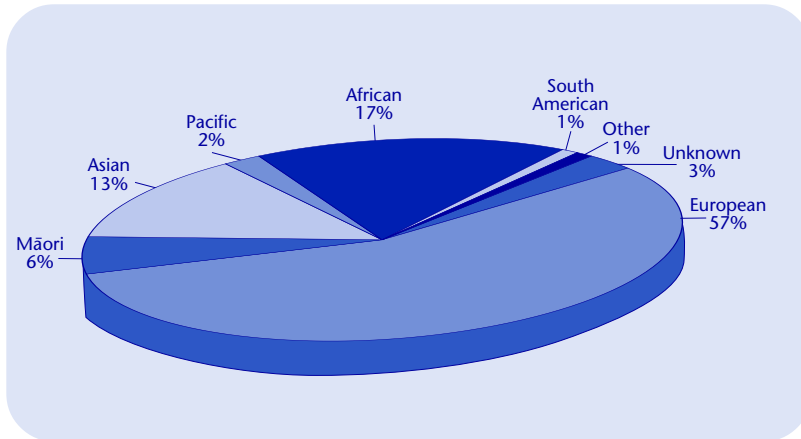




Figure 4: Ethnicity of people diagnosed HIV positive between 1 January 1996 and 31 December 2002 (n= 840)

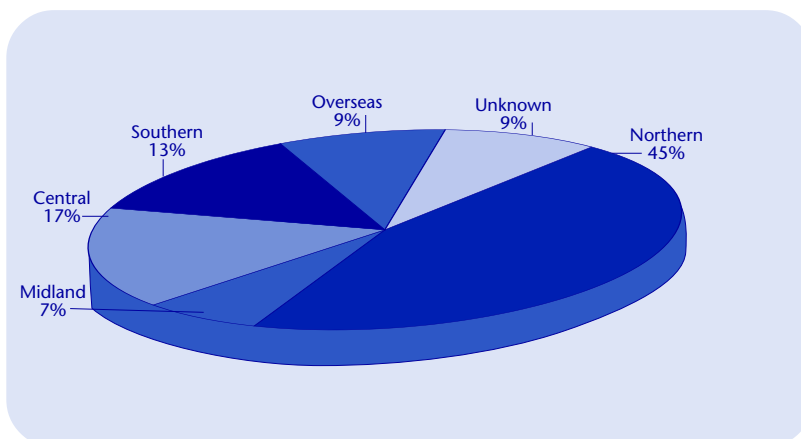


Source: New Zealand AIDS Epidemiology Group

The ethnicity of New Zealand's HIV diagnosed population does not match the New Zealand resident population profile. In 2001 0.2 percent of the New Zealand resident population was African and 7 percent Asian; both these groups are over-represented in New Zealand's diagnosed HIV-positive population (Figure 4). This reflects the higher prevalence of HIV and different patterns of infection and transmission in Africa and Asia.

Most people diagnosed with HIV infection reside in the north and central New Zealand. This reflects the geographic distribution of population groups most vulnerable to HIV infection, in particular MSM and refugees and migrants from high prevalence countries.

Figure 5: Regional distribution of people diagnosed HIV positive between 1 January 1996 and 31 December 2002 (n= 840)



Note: The four regions equate to the four regional health authorities of the mid- to late-1990s.

Source: New Zealand AIDS Epidemiology Group

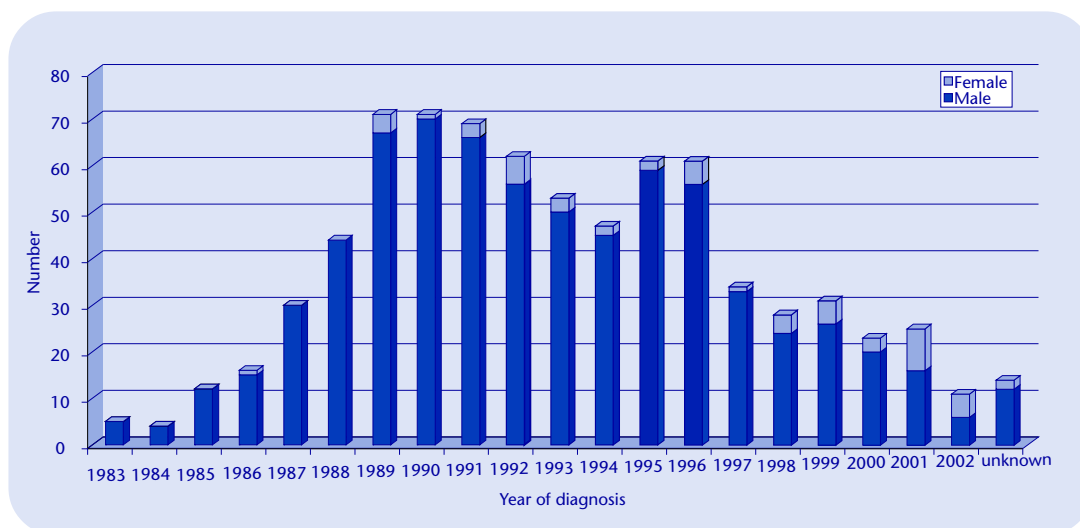


AIDS

As Figures 6, 7 and 8 show, trends in AIDS epidemiology may not reflect trends in HIV epidemiology. AIDS diagnoses peaked in 1989 and have generally declined since then, although they rose temporarily in 1995 and 1996 (see Figure 6). The reasons for this were likely to have been the reduction in unprotected sex among MSM in the mid-1980s and the effective prevention of epidemics in other

population subgroups. Since the mid-1990s incidence has also reduced because of the availability of antiretroviral (ARV) therapies that have delayed the progression of HIV infection. The AIDS epidemic started later in New Zealand compared with other countries, enabling an earlier proactive response by government and the community.

Figure 6: Number of people with AIDS by year of diagnosis, 1983–2002 (n=772)



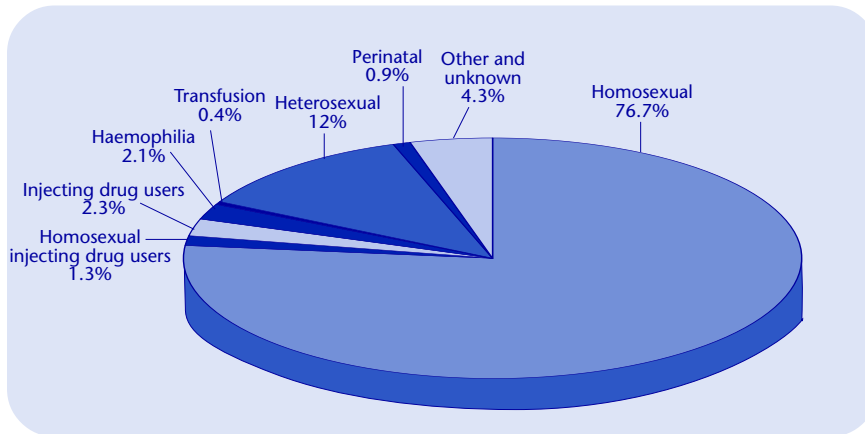
Source: New Zealand AIDS Epidemiology Group





Homosexually acquired AIDS accounted for over three-quarters of people notified with AIDS (see Figure 7). In contrast, homosexually acquired HIV accounted for just over half of HIV diagnoses between 1996 and 2002.

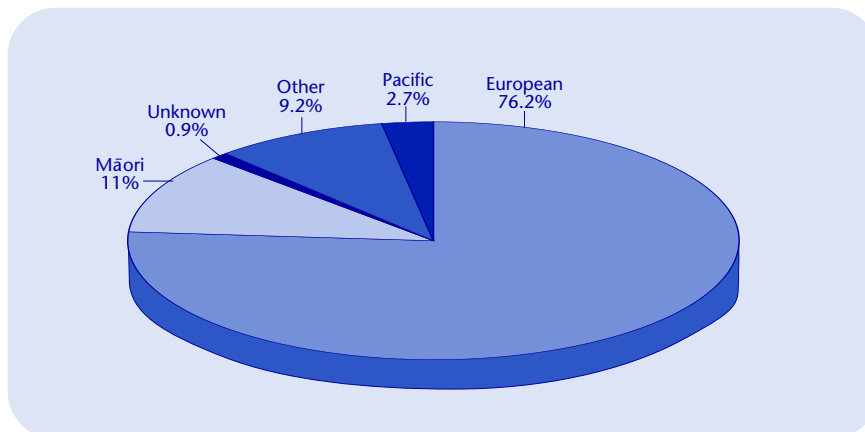
Figure 7: AIDS cases suspected mode of transmission, 1983–2002 (n=772)



Source: New Zealand AIDS Epidemiology Group

Over three-quarters of people with AIDS were of European ethnicity (see Figure 8).

Figure 8: Ethnicity of people with AIDS, 1983–2002 (n=772)



Source: New Zealand AIDS Epidemiology Group



HIV/AIDS action plan target groups

This HIV/AIDS action plan focuses on the groups in New Zealand within which HIV is concentrated and/or which are more likely to practise high-risk behaviours that put them at greatest risk of, and most vulnerable to, HIV infection in New Zealand. These groups require HIV/AIDS specific strategies tailored to meet their particular needs. The groups this plan targets are:

- MSM including men who have sex with men and women (MSMW)
- refugees and migrants from high-prevalence countries
- IDUs
- sex workers.

This plan also focuses on people living with HIV/AIDS (PLWHA is the abbreviation used throughout this document to refer to people living with HIV/AIDS).

People living with HIV/AIDS

A recently published study, *HIV/AIDS Futures New Zealand*, analysed the clinical, social and cultural experiences of 226⁴ PLWHA (Grierson et al 2002). Of the 226 participants, 25 (11 percent) identified as Māori.

The study found that discrimination was a relatively common experience for PLWHA, indicating that societal attitudes towards PLWHA need to be improved. However, the

⁴ Nearly 25 percent of New Zealand's diagnosed HIV-positive population under active care.

majority of PLWHA considered their HIV status an important part of their identity. Nearly half (47 percent) of the respondents were on a pension or benefit. Respondents' median income was \$330 per week. Paying for food and medical services was very difficult for 14 percent and 32 percent of respondents.

Just over 80 percent of respondents were seeing an HIV specialist to manage their HIV and 64 percent were using ARV therapy. Most respondents were concerned about the future efficacy of their treatment. HIV can develop resistance to one or more treatments as a result of its continual mutation, and this resistance can result in treatment failure (Averitt and Thiemann 2001). Of those who took a treatment break (34 percent) the main reasons were lifestyle related (depression, travel, dosing problems) and clinically related (doctor's recommendation, side effects and drug resistance).

The study found that as well as using HIV specialist services and general practitioner services, respondents used a range of ancillary services. Significant proportions used New Zealand AIDS Foundation information and support/counselling services. The non-HIV specific services most likely to be used related to pharmacy needs, financial advice and assistance, legal advice, housing assistance, employment and return-to-work services, drug and alcohol treatment, mental health services, library services, internet access, transport and paid carers.

Men who have sex with men

HIV and AIDS in New Zealand have primarily affected MSM. The 1996 New Zealand AIDS Foundation's research project, *Male Call: Waea Mai, Tane Ma*, provided the first examination of sexual behaviour and the impacts of safer





sex messages among 1852 New Zealand MSM. HIV/AIDS prevention programmes have discouraged unprotected anal sex and encouraged safer sex practices, including condom use. The research found that overall MSM had accepted the importance of using condoms. However, a significant minority continued to engage in unsafe sex. Therefore, transmission continues to occur in this population group. Men who had unprotected casual sex tended to be lower income and non-gay community attached men, who had greater numbers of sexual partners.

The research found several socio-sexual differences between Māori and non-Māori MSM. Compared with non-Māori MSM, Māori MSM were:

- more likely to be younger
- more likely to be on lower incomes and in semi-skilled work
- less likely to feel part of the gay community
- less likely to have had sex with casual partners or outside a regular relationship (Aspin et al 1998).

The findings of the 2002 Gay Auckland Periodic Sex Survey (GAPSS) were largely consistent with the 1996 study (Saxton et al 2002). The GAPSS found that unprotected anal sex was more common among those having anal sex with their current regular partner (65 percent) than among men having anal sex with a casual partner or partners (33 percent). Studies of men who have recently tested HIV-positive suggest that around half of new infections occur in the context of a regular relationship (National Centre in HIV Social Research 2002). The GAPSS found two factors that may be related to this. First, partners who had last tested HIV negative were more likely to engage in unprotected anal sex, although many had had their last test a considerable time before.

Second, over half of those in a regular relationship had had sex with another male in the preceding six months.

Around 20 percent of respondents to the GAPSS agreed that 'HIV/AIDS is a less serious threat than it used to be because of new treatments'. Nearly three-quarters expected someone who knew he was HIV-positive to tell them he was positive before having sex. Overseas studies of MSM have found the undiagnosed HIV-positive population can be 50 percent to 70 percent (Dodds et al 2002; MacKellar et al 2002), but it is not known whether this is similar in New Zealand. The majority (95 percent) of the GAPSS participants agreed that 'condoms are okay as part of sex', but 13 percent said they would sometimes rather risk HIV transmission than use a condom.

The proportion of GAPSS respondents who reported being HIV-positive was 5 percent. This was higher than the proportion in the 1996 sample (2 percent) and is likely to be because GAPSS was carried out in Auckland, and higher rates of HIV infection are found in Auckland compared with the rest of New Zealand. Most (71 percent) of the sample had tested for HIV at least once in their life, with almost a quarter (24 percent) having been tested in the previous six months.

The survey findings suggest there is a need to reinforce and renew safer sex messages, in particular condom use with regular and casual partners. It is also important to provide better and up-to-date information about HIV/AIDS so people are aware of the risks and may be less likely to assume people will know and disclose their HIV status, or rely on outdated HIV negative test results.

Some MSM also have sex with women. Many of these men identify as heterosexual because of the stigma attached to homosexual sex. Such



men are less likely to disclose their sexual practices with men to their female partners so it is possible such men and their female partners are particularly vulnerable to HIV infection. Men who have sex with men and women (MSMW) may be at greater risk of acquiring HIV infection themselves, and may act as a 'bridging population' for HIV between high and low prevalence populations through their sexual practices with both MSM and women.

While interventions that address the complex issues of sexual partnering, practices and identity for MSMW should be considered, they may also benefit from prevention campaigns targeted at MSM. At present, New Zealand epidemiological evidence suggests that very few cases of diagnosed HIV infection in women (less than 5 percent) were acquired through unprotected sex with MSMW. Behavioural research suggests MSMW are more likely than other MSM to use condoms for anal sex with their male partners (Reid et al 1998).

Refugees and migrants from high-prevalence countries

All adult quota refugees are screened for HIV infection as part of the health screening programme offered at the Mangere Refugee Resettlement Centre. Other migrants, asylum seekers and family reunification refugees may not receive HIV testing. Providing effective HIV prevention programmes together with appropriate voluntary testing and counselling services and treatment and support for HIV-positive refugee and migrant groups are challenges as HIV prevention programmes in New Zealand have largely been targeted at MSM. These programmes are unlikely to be appropriate for refugee and migrant communities.

New Zealand has one HIV/AIDS health education programme targeting refugees. The National HIV/AIDS Refugee Health Education Programme targets African refugees nationally. It aims to provide HIV/AIDS training and health promotion for this refugee community, to provide training and support to HIV/AIDS service providers and to develop support networks and a supportive community environment for HIV-positive refugees.

Refugees and migrants bring a set of complex social and cultural challenges that affect HIV care provision. Key issues facing New Zealand health and disability services include: the increase since the 1990s in the number of HIV-positive refugees in New Zealand; language and cultural barriers; the potential numbers of undiagnosed HIV-positive refugees or migrants; the cultural differences that affect acceptance of safer sex practices; the need for specialised national HIV education and destigmatisation campaigns; the lack of culturally appropriate support services for HIV-positive refugees; the stigma and isolation associated with HIV; and the growing demand on personal health services.

Migrant populations, particularly those from high-prevalence areas, may be at higher risk of acquiring HIV infection than the host population. Factors related to this include: demographic and behavioural differences within the immigrant community; difficulties interacting with and integrating into the host society; less access to medical services; the role of women in the migrant population and their ability to negotiate safer sex practices; and cultural, language and communication barriers. Another compounding factor is that HIV-related stigma and shame are often greater in non-Western cultures; fear of disclosure has implications for HIV transmission, particularly for partners, and for access to HIV treatment





and care services. All these factors create specific challenges for control strategies, clinicians and support services. Health professionals seeking more information can access *Refugee Health Care: A handbook for health professionals* through the Ministry of Health's website (www.moh.govt.nz).

Injecting drug users

Injecting drug users (IDUs) are an at-risk population because HIV can be readily transmitted through shared injecting equipment. However, injecting-drug-related HIV epidemics do not remain confined to IDU populations. Most IDUs are young, male and sexually active. Therefore, they are vulnerable to HIV infection not only by sharing injecting equipment but through unprotected sex. Injecting drug use also often overlaps with the sex industry; users may buy or sell sex to finance their drug dependencies.

Preventing HIV in IDU populations requires a comprehensive primary prevention strategy, including access to clean needles and syringes and condoms, drug-dependency treatment and rehabilitation, HIV/AIDS education, legal and social services, and voluntary HIV testing and counselling and psychosocial support.

There is strong evidence to show that effective and humane drug addiction treatment not only reduces drug abuse, but diminishes HIV risk. It is important that drug control policies reduce, not augment, the HIV risk faced by IDUs, and HIV prevention activities must not inadvertently promote drug abuse.

The 2002 Ministry of Health publication *Action on Hepatitis C Prevention* (see www.moh.govt.nz) includes measures for hepatitis C prevention among IDUs that also prevent HIV transmission, for instance, the

needle and syringe exchange initiatives, education around not sharing injecting drug equipment, and surveillance to monitor HIV prevalence as well as hepatitis C seroprevalence.

Sex workers

The sex industry in New Zealand is divided into three main areas: street workers, escort agencies and massage parlours, and private workers. Most sex workers are women, but there are also men and transgendered people who are mainly engaged in street work. Some escort agencies provide male escorts for male and female clients. The sex industry comprises people from all ethnic backgrounds. In recent years anecdotal reports suggest increasing numbers of Asian women coming to work in New Zealand massage parlours.

In 1989 it was estimated that there were around 8500 sex workers in New Zealand (Ministry of Health 1999). However, the true numbers involved throughout any one year are not known. The sex industry has a transient population.

Sex workers have largely adopted safer sex practices, but there are particular sex workers who could be more at risk of coercion into unprotected sex and possible transmission of STIs than other sex workers. While there is little research in this area, anecdotal evidence suggests the most at-risk sex workers include street workers, transgendered sex workers, young and transient sex workers, Māori sex workers, and migrant sex workers. Male and transgendered sex workers are more likely to manage their own sex work activities rather than work for a third party from a venue.

Effective HIV prevention among sex workers addresses the social, economic and legal



environments in which they live and work. Sex workers must be involved in, and empowered by, HIV prevention programmes designed to meet their needs. Efforts must win the co-operation and support of people in positions of control in the sex industry, such as owners and managers of commercial sex venues, and the police. It is essential to tackle the prejudice that sex workers endure, and to weave other concerns into the programmes, such as care for families and children.

The World Health Organization realises the necessity of protecting and promoting the rights of sex workers because of the important role sex workers can play in HIV prevention. The Prostitution Law Reform Act 2003 is expected to assist with promoting HIV prevention and management strategies among sex workers. The Act decriminalises prostitution and aims to: safeguard sex workers' human rights and protect them from exploitation; promote the welfare and occupational health and safety of sex workers; create an environment conducive to public health; and protect children from exploitation.

Implications of HIV/AIDS for other groups

HIV/AIDS has implications for a range of other groups in society, including:

- people with STIs
- young people
- women
- Māori
- Pacific peoples
- prisoners
- uniformed forces
- travellers.

People with sexually transmitted infections (STIs)

The presence of STIs magnifies the risk of HIV transmission as much as 10-fold, since the STI creates additional entry points for the virus and facilitates viral replication. STIs are indicators of unprotected sex, and STIs that cause genital ulcers, such as Herpes Simplex Virus-2 and gonorrhoea, amplify the risk of HIV transmission occurring after exposure to the infection. Anal gonorrhoea in particular is a reliable predictor of unprotected sex among MSM.

A 1996/97 HIV prevalence study of sexual health clinic attenders in Auckland and Christchurch found that 3 percent of MSM were HIV-positive (Connor et al 1997). HIV prevalence in heterosexual men and women was found to be 1 percent for both groups.

Women

Women exposed to HIV during vaginal intercourse may be at greater risk of acquiring it than men exposed to HIV during vaginal intercourse. This is because the HIV viral load in vaginal fluid is generally less than the HIV viral load in semen (Shepard et al 2000) and women have a larger mucosal surface exposed to abrasions during vaginal intercourse that act as portals allowing the virus to enter the bloodstream. More abrasive vaginal intercourse, such as that associated with sexual violence and/or vaginal intercourse while under the influence of alcohol, can exacerbate existing physiological vulnerabilities to HIV transmission.

The 2000 study of New Zealand's HIV infected population under active care concluded that the increasing numbers of women under care (about 19 percent) required new strategies to prevent perinatal HIV transmission. Now that





effective strategies can significantly reduce the risk of HIV transmission from mother to baby are available, the issue of screening and testing for HIV as part of antenatal care has been raised. The issues are discussed and guidance is provided in the 1997 Ministry of Health publication *HIV in Pregnancy: Risk screening guidelines and information for health professionals* and the 2000 publication *HIV/AIDS: Information for health professionals*.⁵

The National Health Committee (NHC) is reviewing policy on HIV testing in pregnancy. In October 2003 it published a discussion document on HIV screening in pregnancy. The report, *Discussion Document: HIV screening in pregnancy*, is available on the Ministry of Health's website. Following analysis of submissions the NHC will be providing advice to the Minister of Health on antenatal HIV screening.

While the number of HIV-positive women in New Zealand is significantly less than the number of men, the progression of HIV in other developed countries suggests women, particularly young women, should not be overlooked as a target group for HIV awareness and prevention training.

Young people

In New Zealand, young people have higher STI rates than older people. Therefore, sexual and reproductive health promotion programmes (including STI and HIV prevention education) need to be designed for young people.

Overseas in areas where HIV/AIDS are subsiding or declining, it is primarily because young men and women are being given the primary prevention tools and incentives to adopt safe behaviours (UNICEF et al 2002). The UNICEF, UNAIDS and WHO publication

⁵ Accessible at www.moh.govt.nz.

Young People and HIV/AIDS: Opportunity in crisis sets out the following 10-step strategy to prevent HIV/AIDS in relation to young people:

1. End the silence, stigma and shame.
2. Provide young people with knowledge and information.
3. Equip young people with the life skills to put knowledge into practice.
4. Provide youth-friendly health services.
5. Promote voluntary and confidential HIV counselling and testing.
6. Work with young people, promote their participation.
7. Engage young people who are living with HIV/AIDS.
8. Create safe and supportive environments.
9. Reach out to people most at risk.
10. Strengthen partnerships, monitor progress.

Māori

There is minimal research data about Māori and HIV/AIDS, but a number of factors suggest Māori may be vulnerable to exposure to HIV infection:

- Māori are disproportionately on low and very low incomes
- Māori trans-Tasman migration
- lack of information
- lack of access to culturally appropriate services
- lack of access to health resources, such as condoms (Te Puni Kōkiri 1994).

Māori are also over-represented in other populations vulnerable to HIV exposure and/or transmission on exposure. Māori are a youthful population and experience disproportionately higher STI rates. A study of patterns of disease and HIV testing at sexually



transmitted disease clinics found that 22 percent of subjects had voluntary HIV testing, but that Māori were tested at 60 percent of the European rate (Connor et al 1997).

The AIDS Epidemiology Group reports that most Māori with HIV/AIDS are MSM. The 1996 New Zealand AIDS Foundation's research project *Male Call: Waea Mai, Tane Ma* found no statistically significant difference between risk behaviour among Māori and non-Māori MSM. However, as with non-Māori, a cause of concern is the significant minority likely to have engaged in highly unsafe sex (14 percent). Highly unsafe sex among Māori MSM was associated with being younger, being on a lower income, and having sex with casual partners (Aspin et al 1998).

Pacific peoples

The youthful age structure of the Pacific population and Pacific youths' disproportionate STI rates suggests that Pacific young people may be vulnerable to exposure to HIV infection. Since 1996, 17 Pacific people have been diagnosed with HIV in New Zealand. This represents 3 percent of the total number diagnosed with HIV since 1996.

Because New Zealand's Pacific population retains close social and economic ties with their countries of origin, New Zealand's response to HIV/AIDS needs to take account of HIV/AIDS in the Pacific region. Heterosexual transmission through unprotected sex is the most common mode of HIV transmission in the Pacific region, with most reported infections being in young people. In recent years, the region has experienced a substantial increase in STIs, and there is a worrying trend of steeply increasing rates of HIV infection (*Reproductive Health Commodity Security in Pacific Island Countries and Pacific Plan of Action*, 2003). Since 1996 11 people diagnosed with HIV in New Zealand

are thought to have acquired their infection in a Pacific Island country (AIDS Epidemiology Group 2003). A study of patterns of disease and HIV testing at sexually transmitted disease clinics found that 22 percent of subjects had voluntary HIV testing, but Pacific people were tested at 25–30 percent of the European rate (Connor et al 1997).

Prisoners

Removed and marginalised from society, prisoners can be at special risk of HIV infection, through consensual or forced sex, injecting drug use, unsafe tattooing practices, and insufficient HIV prevention education and services. In New Zealand, 50 percent of the male prison population is Māori and nearly 60 percent of the female prison population is Māori. Any HIV prevention initiatives among New Zealand's prison population will need to take account of issues for Māori prisoners.

The Department of Corrections and Ministry of Health have developed a communicable diseases policy that includes initiatives relevant to HIV prevention: offering HIV tests to inmates who self-identify as 'high risk', provision of health kits that include condoms, and the provision of condoms on request. These initiatives are being trialled in selected prisons.

Uniformed forces

The United Nations Declaration of Commitment on HIV/AIDS calls for inclusion, by 2003, of HIV/AIDS awareness and training into guidelines for defence force personnel involved in international peace-keeping operations. Several aspects of the military environment put armed forces at risk. One of the most important factors is the practice of posting personnel away from their own communities and families. This not only frees





soldiers from the discipline they might be subject to in their own communities, it removes them from their regular sexual partners. The resulting loneliness, stress and sexual tension can increase risk taking. A study of Dutch soldiers on a five-month peace-keeping mission in Cambodia found that 45 percent had sexual contact with prostitutes or members of the local community during their deployment.

New Zealand Defence Force (NZDF) entrants are one of the serially tested low-risk populations included in the hepatitis C surveillance programme, which includes HIV testing. The NZDF also provides confidential counselling and voluntary testing before deploying personnel on peace-keeping missions and on their return. NZDF personnel attending courses in the United States of America are also required to undergo HIV testing.

Travellers

New Zealanders need to be informed of the risks associated with having unprotected sex overseas and with visitors to New Zealand. Given that New Zealand's youth have a tradition of having an 'overseas experience', it is important for them to be informed about protecting themselves from HIV infection while overseas, including in the Pacific. Current practice is for health advice for international travellers to highlight the risk of HIV transmission through unsafe sexual behaviour or injecting drug use.

New Zealand's response to HIV/AIDS

The 1990 New Zealand Strategy on HIV/AIDS clearly established the Ottawa Charter for Health Promotion as the framework for HIV

prevention. The Government is committed to continuing to implement the Ottawa Charter in its management of the HIV epidemic. The principles of health promotion provide a framework for community-based organisations to work with and beside communities affected by the epidemic to promote behaviours that significantly reduce HIV transmission. The five components of the Ottawa Charter framework are:

- build healthy public policy
- reorient health services
- create supportive environments
- develop personal skills
- strengthen community action.

As well as basing its response to HIV/AIDS on the Ottawa Charter, New Zealand has taken a primary prevention approach:

The purpose of primary prevention is to limit the incidence of disease by controlling causes and risk factors. Primary prevention involves two strategies that are often complementary and reflect two views of aetiology. It can focus on the whole population with the aim of reducing average risk (the population strategy) or on people at high risk as a result of particular exposures (the high-risk individual strategy) (Beaglehole et al 1993).

Condoms and clean needles and syringes

Proper use of condoms and using clean needles and syringes are the two principal HIV/AIDS primary prevention strategies in New Zealand. The Joint United Nations Programme on HIV/AIDS (UNAIDS) states that 'condoms, properly used, represent a proven effective means for preventing the transmission of HIV, other



traditional sexually transmitted infections and pregnancy' (UNAIDS 2000). It further suggests:

for a person already infected with HIV, condom use during sexual intercourse is still very important, both to avoid onward transmission, as well as to prevent re-infection with HIV, which could make their condition more serious. It is essential that people are made aware of the importance of consistent condom use. Education efforts should therefore aim to destigmatise condom use, making it acceptable and normal behaviour. Among young people, studies have shown that acceptance by their peers significantly increases the acceptability of condoms.

Injecting drug users who continue to inject are encouraged to:

- use only sterile needles, syringes and injecting equipment
- use only their own outfits if new outfits are unavailable
- clean used injecting apparatus with bleach and water.

In addition, IDUs should also practise safer sex.

Injecting drug users should avoid contact with another person's blood, for example, via tourniquets when assisting someone to inject or injecting someone else. Hands must always be washed before and after injecting. Researchers have found that soaking needles and syringes in full strength household bleach for a minimum of 60 seconds will destroy HIV, but doubt remains as to the degree of protection this gives from hepatitis C.

HIV/AIDS treatments

Current ARV agents for HIV/AIDS can be divided into two major classes of drugs:

- protease inhibitors (PIs)
- reverse transcriptase inhibitors (RTIs), which are further divided into nucleoside (NRTI) and non-nucleoside (NNRTI) subclasses.

Evidence shows that a combination of ARV agents, usually including two NRTIs and one protease inhibitor or one NNRTI, is the most effective treatment available to suppress HIV replication. This is reflected clinically in a person's decreased incidence of opportunistic infections, decreased incidence of hospitalisation, and increased ability to return to the normal functions of daily living. It is also reflected in lower viral loads (often to undetectable levels) and more CD4 cells.

Sustainability of treatments

UNAIDS and WHO state that:

it is now recognised that the sustainability of the therapeutic response to antiretrovirals depends on the level of suppression of viral replications. Regimens which only partially suppress replication will ultimately promote the emergence of resistance. The aim of therapy therefore is the full suppression of replication to below detectable levels by the most sensitive assays available.

One factor influencing the development of drug-resistant strains is a person's non-adherence to treatment regimens.





UNAIDS and WHO state that:

inadequate adherence has profound implications. A rapid rate of viral replication, combined with a high rate of mutation, can lead to the development of resistance particularly in the presence of selective pressure by antiretroviral therapies. Resistance can develop if drug doses are inadequate or doses are missed.

Best practice: what works?

The UNAIDS Report on the *Global HIV/AIDS Epidemic 2002* noted that there was clear evidence of what works and outlined the 'prevention essentials' that apply regardless of a country's HIV prevalence rates. The report noted that evidence shows that 'effective HIV prevention combines society-wide strategies with particular foci on those parts of the population most at risk. Society-wide strategies put young people at their centre'. STIs are covered in the Ministry of Health's 2003 *Sexual and Reproductive Health: A resource book for health care organisations* and the approaches include society-wide strategies for preventing STIs, including HIV, and it puts young people at its centre. This HIV/AIDS Action Plan focuses on those populations most affected by, and most at risk of, HIV infection, namely PLWHA, MSM (including gay and bisexual men), refugees and migrants from high prevalence countries, IDUs and sex workers. The UNAIDS report also notes that young people need to be at the centre of strategies targeted at populations most at risk.

Overall effective prevention approaches recognise that:

- **Knowledge is not enough.** Behavioural change requires locally-appropriate, targeted information, training in negotiation and decision-making skills, social and legal support for safer behaviours, access to the means of prevention (eg, condoms and clean needles and syringes) and motivation for behavioural change.
- **The distribution of risk and vulnerability in societies varies greatly, as does the ability to locate and work with specific vulnerable populations.** No single prevention approach can be effective everywhere. To produce and sustain behavioural change on a national scale effectively, focused prevention programmes will involve multiple components, developed with input from each targeted population, to address specific needs of vulnerable groups and the many factors influencing behavioural change.
- **General population efforts are important, especially for the young.** Effective national programmes take into account the need to raise awareness, knowledge and HIV prevention and care skills among the general population, especially the young. Young people need to have the knowledge and skills to make safe choices and to have access to youth-friendly services that include sexual and reproductive health services and access to condoms. Special attention should be paid to vulnerable young people and those at high risk. Successful youth targeted programmes and services involve young people in their design and work with young people to promote their participation.



- **Partnerships are essential for effective prevention.** Multiple programmes in multiple populations are needed, so it is crucial to create partnerships with the different groups affected.
- **Central government policy leadership is essential to an effective response.** Leadership and action are needed to set the direction for a national response and initiate the development of policies that determine the strategy for managing the epidemic.
- **Half-measures bring, at best, partial results.** Interventions that do not achieve sufficient coverage will fail to have a significant effect.

Prevention depends on an environment of openness and inclusion that enables all people, including those living on the margins of society, to take control over and improve their health, access voluntary testing, seek and receive treatment, alter their behaviour, and become allies in the fight against HIV/AIDS. Successful responses challenge the stigma and discrimination around HIV/AIDS, counter harmful gender norms and discrimination (including homophobia) faced by communities most at risk of HIV infection, protect the rights of those infected and affected by HIV, and include marginalised groups as active participants rather than mere beneficiaries. This includes taking a harm reduction approach to IDUs and the sex industry.

Prevention is enhanced when it is linked to care and support. People are more likely to get tested for HIV if they know treatment is available. Voluntary counselling and testing services are an additional entry point for providing advice and support, and for behavioural change; they offer an opportunity for people to talk with medical and other trained staff, and discuss how they might prevent further spread of the infection.

People living with HIV/AIDS need to be seen as leaders in prevention and care. The GIPA principle (Greater Involvement of People Living with HIV/AIDS), as set out in the 1994 Paris AIDS summit declaration, recognises that people who live with the disease add immeasurable value and impetus to the response. They help personalise the epidemic and bring home to the wider public, political and civil society, institutions and policy-makers that HIV is everyone's problem. This challenges people's prejudices about persons living with HIV infection and so helps to counter stigma and discrimination. Involving PLWHA can also assist in their personal empowerment, reduce their feelings of isolation, and lead to their improved wellbeing.

Early and effective treatment of STIs

This is an important component of HIV prevention. Therefore, the HIV/AIDS Action Plan needs to be implemented in tandem with *Sexual and Reproductive Health: A resource book for health care organisations*.

Reach out to people most at risk. In low prevalence settings the UNAIDS report advocates early, large-scale interventions among certain high risk groups, typically MSM, IDUs and sex workers, as this can stave off a general epidemic. People at risk in these contexts are not isolated; they mix across populations. The report also notes that these groups are usually highly stigmatised and marginalised. Society-wide strategies, including mainstream STI prevention and services inclusive of HIV, may have little or no impact on these groups. Outreach and involvement of the at-risk groups in programme design and delivery are essential. Programmes and services need to be tailored to the specific realities and needs of the people they are intended to reach and must bring the services





to where they work, live and socialise. This requires multiple access points within a range of providers best situated for access and outreach to particular target groups.

The UNAIDS report highlights the components of strategies that work including:

- easy access to a range of good quality, free or affordable condoms and clean needles and syringes
- HIV/AIDS education and life-skills training
- mass media communication
- voluntary counselling, testing and referral to appropriate care services
- treatment of STIs
- active involvement by targeted groups (PLWHA, MSM, refugees and migrants from high prevalence countries, sex workers, IDUs), parents and other key stakeholders
- efforts to reduce social and economic inequalities.





HIV / AIDS Action Plan

1. Societal attitudes, values and behaviour

Goal

A greater awareness and understanding across all members of society about the causes, behavioural risk factors and implications of HIV/AIDS for different groups, and a community-wide commitment to preventing HIV transmission and minimising its personal and social impacts.

Recommended action points

Objective 1:

Ensure HIV awareness and prevention training is a key component of sexual and reproductive health education and promotion programmes, particularly those targeting young people.

Actions

Ensure sexual and reproductive health education and promotion programmes targeting the general population, particularly young people, include information that increases awareness of and knowledge about HIV/AIDS, including:

- who is at risk of HIV infection and why
- how to prevent HIV infection, including regular condom use for anal and vaginal intercourse and clean needles and syringes for injecting drug use
- the risks of relying on a healthy appearance, disclosure of HIV status and/or a previous negative HIV test
- the availability of voluntary HIV testing and counselling, and HIV treatment and care services, including the prevention of mother-to-baby HIV transmission
- the need for evidence-based and targeted prevention strategies to communities who are vulnerable to HIV infection, for example, men who have sex with men (MSM) (including gay and bisexual men), sex workers, injecting drug users (IDUs), and refugees and new migrants from high prevalence countries.

Interpretation

DHB Public Health Units, New Zealand Family Planning Association (NZFPA) and a range of Māori, Pacific and other non-governmental organisations already provide sexual and reproductive health education and promotion programmes that cover HIV/AIDS prevention aimed at young people. The Ministry of Health recommends that as they review and update the information in their programmes they should ensure all the points covered in this action area are adequately covered.

The sexual health component of the Health and Physical Education curriculum for school students already includes information on HIV/AIDS. When the curriculum is next reviewed and updated it will be necessary to ensure that it includes adequate information on all the points covered in this action area.





**Objective 2:
Decrease stigma and discrimination surrounding HIV/AIDS.**

Action	Interpretation
Develop HIV/AIDS destigmatisation programmes tailored to the needs of men who have sex with men (MSM), refugees and migrants from high-prevalence countries, injecting drug users (IDUs), sex workers and people living with HIV/AIDS (PLWHA).	<p>Even among the communities most affected by HIV/AIDS in New Zealand, particularly refugee and migrant communities, stigma can exist. The Ministry of Health has in place a contract for a destigmatisation programme working within communities from African refugee backgrounds. It is anticipated that this programme will expand to other communities, given the availability of adequate resources.</p> <p>The Ministry of Health also has existing contracts with non-governmental organisations (NGOs) providing HIV prevention and support services to MSM, IDUs, sex workers and PLWHA. When these contracts are being renewed the Ministry will consider whether the destigmatisation outputs in these contracts are adequate and consider, given the availability of resources, expanding existing destigmatisation programmes.</p>
Develop and implement an HIV/AIDS destigmatisation campaign targeting the general population.	The Ministry of Health is developing a mass media campaign on sexual and reproductive health, and it will include information designed to reduce HIV/AIDS stigma.



Objective 3:**Improve public health outcomes and ensure the protection of human rights and freedom from discrimination.**

Action	Interpretation
Ensure legislative and policy frameworks for HIV and AIDS surveillance and notification maximise the potential impact on public health practice and outcomes, and minimise any human rights and privacy impacts on individuals living with or affected by HIV/AIDS.	The Ministry of Health is reviewing the Health Act 1956, including notifiable diseases and conditions. All recommendations, including those for HIV/AIDS, will take account of human rights and privacy issues.
Ensure that legislative and policy frameworks for HIV testing, for the general population or a defined population, are evidence-based and minimise human rights and privacy impacts on individuals living with or affected by HIV/AIDS.	The Ministry of Health will ensure reviews of the relevant Acts and policy frameworks take account of this action.
Ensure central government agencies work in partnership with the New Zealand Prostitutes Collective to produce guidelines for the occupational health and safety of sex workers.	The Ministry of Health is working with the New Zealand Prostitutes Collective, Occupational Safety and Health, New Zealand Police, Ministry of Justice and other stakeholders and health providers to develop guidance and advice for the health sector with regard to fulfilling its role in a decriminalised sex industry context.





Objective 4:

To demonstrate leadership in, and commitment to, HIV/AIDS prevention and treatment nationally and internationally.

Action	Interpretation
<p>Continue to provide a range of evidence-based strategic, intersectoral, and operational policy advice on HIV/AIDS, including medical and technical advice.</p>	<p>The Ministry of Health will continue to take responsibility for these functions.</p>
<p>Share knowledge and lessons learned and provide assistance in response to requests by the South Pacific region to strengthen its national and regional capacity to respond to the HIV/AIDS epidemic.</p>	<p>The Government continues to provide assistance and support for HIV/AIDS prevention activities in the South Pacific through the New Zealand Agency for International Development.</p>
<p>Participate in regional and global initiatives that aim to strengthen the national capacity of countries to manage the HIV/AIDS epidemic.</p>	<p>Successive governments have participated in regional and global initiatives that aim to strengthen the national capacity of countries to manage the HIV/AIDS epidemic and this is intended to continue.</p>
<p>Monitor the implementation of the Declaration of Commitment on HIV/AIDS (Global Crisis – Global Action) from the United Nations Special Session on HIV/AIDS as well as other regional and international declarations relating to HIV/AIDS prevention and care.</p>	<p>The Government reports from time to time to the United Nations and other forums on its HIV/AIDS prevention and treatment programmes. These reports will provide opportunities to consider how well New Zealand is implementing the Declaration of Commitment on HIV/AIDS.</p>



2. Personal knowledge, skills and behaviour

Goal

Individuals, particularly men who sex with men (MSM), refugees and migrants from high-prevalence countries, injecting drug users (IDUs), sex workers, and people living with HIV/AIDS (PLWHA), have the knowledge, skills, confidence and motivation to protect themselves against HIV/AIDS.

Recommended action points

Objective:

Ensure MSM, refugees and migrants from high prevalence countries, IDUs, sex workers, and PLWHA have the knowledge and skills to make safe choices and practise safer sex.

Actions

Support and build on existing HIV/AIDS prevention, education and skills training programmes targeted at MSM. In particular, develop initiatives to:

- maintain the promotion of primary HIV prevention strategies for MSM, in particular regular condom use for anal intercourse (and vaginal intercourse for men who have sex with men and women) and clean needles and syringes for injecting drug use
- ensure MSM have access to condoms and lubricants, as their primary strategy for preventing HIV transmission
- ensure the coverage of HIV prevention strategies for MSM is based on the underlying geographic and demographic distribution of MSM communities
- ensure prevention messages for MSM continue to be innovative and reflect the diffuse and diverse nature of the MSM populations
- ensure young MSM receive targeted HIV prevention messages
- ensure peer education and community-based leadership are maintained and extended among MSM to assist HIV prevention
- ensure providers of HIV prevention services for MSM continue to collaborate with services providing HIV prevention services for other communities vulnerable to infection
- provide information on the risks of relying on disclosure of HIV status and/or a previous negative HIV test
- provide information on the availability of voluntary HIV testing and counselling services and HIV treatment and care services.

Interpretation

The Ministry of Health has a contract with the New Zealand AIDS Foundation (NZAF) for comprehensive HIV/AIDS education and health promotion services for MSM. The NZAF undertakes national campaigns, supported by local services in each region, promoting safer sex among MSM.





Actions

Support and build on existing HIV/AIDS prevention, education and skills training programmes for **refugees and migrants from high-prevalence countries**. In particular, develop initiatives to:

- maintain the promotion of culturally appropriate primary HIV prevention strategies for refugees and migrants from high-prevalence countries (including regular condom use for vaginal and anal intercourse and clean needles and syringes for injecting drug use)
- ensure refugees and migrants have access to condoms and clean needles and syringes
- maintain and extend current models of HIV prevention among refugees, for example, the Refugee Health Education Programme
- ensure the coverage of HIV prevention strategies for refugees and migrants is based on the underlying geographic and demographic distribution of those communities
- ensure peer education and community-based leadership are maintained and extended among refugees and migrants from countries where there is a high HIV prevalence to assist HIV prevention
- provide information on the risks of relying on disclosure of HIV status and/or a previous negative HIV test
- provide information on the availability of voluntary HIV testing and counselling services and HIV treatment and care services
- ensure providers of HIV prevention services for refugees and migrants from high-prevalence countries continue to collaborate with services providing HIV prevention services for other communities vulnerable to infection.

Interpretation

The Ministry of Health has a contract with an NGO to provide the HIV/AIDS Refugee Health Education Programme. The programme works with communities from African refugee backgrounds. It is anticipated that this programme will expand to other communities, given the availability of adequate resources.

It will be difficult to determine the geographic and demographic distribution of communities from refugee and migrant backgrounds, unless attention is paid to surveillance, methods of data collection and possibly working with Statistics New Zealand to identify where these groups are settled.

The Ministry of Health currently funds some national resources to support train-the-trainer initiatives in African migrant communities, and it is anticipated that this programme will expand, given the availability of adequate resources.



Actions

Support and build on existing HIV/AIDS prevention, education and skills training programmes targeted at IDUs. In particular, continue to fund initiatives to:

- ensure using clean needles and syringes continues to be promoted as the primary HIV prevention strategy for IDUs
- ensure IDUs have access to clean needles and syringes
- ensure peer education and community-based leadership are maintained and extended among IDUs to assist HIV prevention
- ensure the prevention of HIV among IDUs is consistent with the Hepatitis C Action Plan
- provide information on the risks of relying on disclosure of HIV status and/or a previous negative HIV test
- provide information on the availability of voluntary HIV testing and counselling services and HIV treatment and care services
- ensure providers of HIV prevention services for IDUs continue to collaborate with services providing HIV prevention services for other communities vulnerable to infection.

Interpretation

The Ministry of Health has regionally-based contracts with NGOs to provide co-ordination and education services for IDUs and to provide clean needle and syringe exchange services.





Actions

Support and build on existing HIV/AIDS prevention, education and skills training programmes targeted at sex workers and employers of sex workers. In particular, continue to fund initiatives to:

- ensure sex workers in the range of their operating environments continue to have access to health information and products, such as condoms and lubricants, that significantly reduce the risk of HIV infection
- ensure the development of resources and peer education programmes promoting safer sex behaviours to female, transgendered, young, Māori, Pacific and migrant sex workers; as well as emerging groups entering sex work such as male and migrant sex workers from other Asian and Pacific countries
- ensure peer education and community-based leadership are maintained and extended among sex workers to assist HIV prevention
- provide information on the risks of relying on disclosure of HIV status and/or a previous negative HIV test
- provide information on the availability of voluntary HIV testing and counselling services and HIV treatment and care services
- ensure providers of HIV prevention services for sex workers continue to collaborate with services providing HIV prevention services for other communities vulnerable to infection
- ensure emerging population groups entering sex work receive personal skills to prevent HIV transmission.

Interpretation

The Ministry of Health funds the New Zealand Prostitutes Collective to promote safer sex practices among sex workers in each region. The Ministry needs to assess whether the price of current contracts is sufficient to meet the needs of new populations and any additional work that might arise out of the enactment of the Prostitution Reform Act 2003. Medical Officers of Health have new responsibilities under this legislation and additional funding may be required to fund the activities for which they are now responsible. The Ministry is scoping this work.



Actions

Support and build on existing support, education and skills training programmes for PLWHA including ensuring:

- PLWHA have input into the development of any programmes targeted at them.
- appropriate programmes are delivered to PLWHA to prevent further transmission of HIV
- peer education and community-based leadership are maintained and extended among PLWHA to assist HIV prevention.

Interpretation

The New Zealand AIDS Foundation is funded to provide counselling and support services for PLWHA, including HIV-positive peer education, working with other HIV support groups, developing resources for HIV-positive men, assisting Body Positive community groups to provide retreats for HIV-positive men, delivering treatment information, providing the 'human face' of HIV. In the main these services are directed at HIV-positive men who have sex with men. Extending these services to HIV-positive women and developing culturally appropriate services for PLWHA from refugee or migrant backgrounds should be considered, given the availability of adequate resources.





3. Programmes and services

Goal

Accessible, effective programmes and services that are working together regionally and nationally to prevent HIV transmission, particularly for men who have sex with men (MSM), refugees and migrants from high-prevalence countries, injecting drug users (IDUs) and sex workers, and to minimise the personal and social impacts of the HIV epidemic for people living with HIV/AIDS (PLWHA).

Recommended action points

Objective 1:

Improve access to and coverage of services, particularly for PLWHA, MSM, refugees and migrants from high prevalence countries, IDUs and sex workers.

Actions	Interpretations
Review the accessibility and coverage of HIV/AIDS treatment and support services for PLWHA, including accessibility for people with disabilities.	The Ministry of Health, DHBs and providers of support services to PLWHA need to consider this action within their existing resource constraints.
Review the accessibility and coverage of HIV/AIDS prevention, testing and treatment and support services for MSM (including gay and bisexual men), refugees and migrants from high-prevalence countries, IDUs and sex workers.	The Ministry of Health and DHBs need to consider this action within their existing resource constraints.
Review the funding and infrastructure of HIV treatment services and identify future requirements, including workforce requirements.	The Ministry of Health and DHBs need to consider this action within their existing resource constraints.
Provide culturally appropriate support and counselling for HIV-positive refugees and migrants.	The Ministry of Health has published a guide for health professionals, <i>Refugee Health Care: A handbook for health professionals</i> , which is available from the Ministry website (www.moh.govt.nz).



Objective 2:**Create pathways of care between preventative, primary and specialist health care.**

Actions	Interpretations
Review pathways of care for PLWHA including identifying factors that can improve co-ordination and collaboration between services.	This action should be incorporated into the planned work on developing an Integrated Care Pathway for Primary Health Organisations. PLWHA should have input to this work.
Develop guidelines that ensure health care professionals work together to establish effective local protocols for testing, managing and following-up people who have tested HIV-positive.	Providers of sexual and reproductive health education programmes, sexual health clinical services, secondary care specialists, PHOs and other primary health care providers could work in conjunction with PLWHA to develop local protocols.
Set up systems to ensure continuity of care from primary to specialist care for people who have tested HIV positive.	Sexual health services, secondary care specialists, PHOs and other primary care providers could work in conjunction with PLWHA to develop systems for ensuring continuity of care.
Set up systems to ensure prevention programmes are linked to testing, support and treatment services.	Providers of sexual and reproductive health education programmes, sexual health clinical services, secondary care specialists, PHOs and other primary health care providers may choose to work in conjunction with PLWHA to develop systems for linking testing, support and treatment services.





**Objective 3:
Strengthen primary care services.**

Actions	Interpretations
<p>Explore the feasibility of bulk supply contracts for condoms through PHARMAC to the New Zealand Prostitutes Collective, the New Zealand AIDS Foundation, the New Zealand Family Planning Association, and other primary health care providers and sexual health promoters working in public health units.</p>	<p>PHARMAC has been actively exploring avenues for providing equitable access to funding for bulk supply of condoms. PHARMAC supports the idea of subsidising bulk supplies of condoms for certain organisations, and will continue to develop sustainable methodologies for supply, subject to funding being available.</p>
<p>Ensure collaboration occurs between providers of sexual and reproductive health services and HIV-specific services.</p>	<p>The Ministry of Health’s contracts with the NGOs include requirements to collaborate. DHBs’ sexual health services, secondary care specialists, PHOs and other primary health care providers may need to review the adequacy of their collaboration requirements.</p>
<p>Increase the skills and expertise among primary health care professionals around the offering of an HIV test, including how to ask questions about sexual and drug injecting behaviour, what to do when a person is diagnosed as HIV-positive, providing HIV prevention information, explaining partner notification, and giving information about access to treatment and care for people diagnosed as HIV-positive.</p>	<p>To achieve this action sexual health and HIV/AIDS specialists, PHOs and other primary health care providers will need to build relationships, share knowledge and work collaboratively. Specialist out-reach clinics where a specialist runs a clinic in a general practice and provides education and training to general practice staff is an example of how this might work.</p> <p>The Ministry of Health has general information and resources accessible on its website that can assist primary health care providers. Resources include, <i>HIV/AIDS Management Guidelines: Voluntary counselling and testing for diagnosis of HIV infection</i> (2002), <i>HIV in Pregnancy: Risk screening guidelines and information for health professionals</i> (1997) and <i>HIV/AIDS: Information for health professionals</i> (1999) available at the Ministry’s website (www.moh.govt.nz).</p>



Actions	Interpretation
	<p>The Australasian Society for HIV Medicine (ASHM) has published a comprehensive guide for primary care, <i>HIV/Viral Hepatitis: A guide for primary care</i>. ASHM's website is www.ashm.org.au.</p>
<p>Provide information and support to primary health care providers on contact tracing and the legal duties of individuals when they are diagnosed as HIV-positive.</p>	<p>Health professionals' usual practice is to encourage people diagnosed as HIV-positive to take personal responsibility for contact tracing their sexual partners and/or offer contact tracing services. People who are HIV-positive have a duty to take steps to prevent transmitting the infection.</p> <p>In developing the Public Health Bill legislative issues relating to contact tracing in general are being considered.</p>
<p>Ensure appropriate access to voluntary HIV testing and counselling services for refugees and migrants from countries where there is a high HIV prevalence, including information in an individual's first language about HIV and access to interpreting services.</p>	<p>Interpreter services are available for pre- and post-HIV testing and counselling for refugees and at hospital-based sexual and reproductive health services for migrants. However, interpreter services for pre- and post-HIV testing and counselling are not generally available to primary health care providers, such as general practitioners and independent midwives. To fill this gap reprioritisation would be required.</p>
<p>Ensure midwives and lead maternity carers (LMCs) are aware of the need to encourage and offer voluntary HIV testing and counselling to pregnant women with HIV risk indicators to minimise the risk of mother-to-baby HIV transmission.</p>	<p>The Ministry of Health has general information and resources accessible on its website that can assist health professionals. Resources include, <i>HIV in Pregnancy: Risk screening guidelines and information for health professionals</i> (1997), <i>HIV/AIDS: Information for health professionals</i> (1999) and <i>HIV/AIDS Management Guidelines: Voluntary counselling and testing for diagnosis of HIV infection</i> (2002) available at the Ministry's website (www.moh.govt.nz). The National Health Committee (NHC) has published a discussion document on HIV screening in pregnancy. Following completion of its review of the current policy and practice of HIV screening in pregnancy, the NHC will provide advice and recommendations to the Minister of Health.</p>





**Objective 4:
Strengthen specialist and secondary care services.**

Actions	Interpretations
<p>Ensure specialists and others providing secondary care services have access to the resources necessary for providing quality health care for HIV-positive people. In particular, these resources should include access to HIV viral load testing, CD4 lymphocyte testing, HIV antiretroviral (ARV) resistance testing, an adequate range of ARV medications, inpatient and outpatient care facilities, and appropriate support services, such as social worker and community-based nursing.</p>	<p>Specialists and others providing secondary care services have access to the resources necessary for providing quality health care for HIV-positive people. There is an expectation that this will continue to be the case.</p>
<p>Ensure specialists and secondary care services are available in an equitable manner to people with HIV infection in New Zealand regardless of their district of residence.</p>	<p>One expectation of service coverage is that people have access to health and disability services regardless of where they live. However, it is recognised that access to some specialist services may mean people have to travel.</p>
<p>Review the cultural appropriateness and adequacy of palliative care services in terms of the numbers of actual and projected incidence of AIDS diagnoses in New Zealand.</p>	<p>The New Zealand Palliative Care Strategy includes culturally appropriate palliative care services as part of its vision. Under the strategy nine directions for achieving the vision are to be implemented over a five- to 10-year period.</p>
<p>Identify and resolve regional inconsistencies in the funding streams for respite care and support services for PLWHA.</p>	<p>To initiate work on this action the Ministry of Health and DHBs would need to work together to review the funding streams for respite care and support services for PLWHA. This work is not currently planned for.</p>



Actions

Ensure up-to-date and accurate research and information guides the provision, funding and prescribing of ARV treatments, including the development of prescribing protocols for specific population groups.

Interpretations

PHARMAC takes advice from the antiretroviral subcommittee of the Pharmacology and Therapeutics Advisory Committee (PTAC), a dedicated subcommittee that provides clinical advice during the funding decision process. Two proposals for the funding of protease inhibitors are being actively progressed.

The Ministry of Health also has an expert advisory group, the AIDS Medical and Technical Advisory Committee.





4. Information

Goal

An information and evidence base that enables and supports policy and programme development, surveillance of HIV/AIDS, monitoring of progress and clinical and service decision-making.

Recommended action points

Objective 1: Better understand the trends.

Actions

Include information on the number of HIV tests through existing clinic-based surveillance of the major STIs.

Conduct regular, unlinked, anonymous studies of HIV prevalence among sexual health clinic attenders, and, as well as age, ethnicity, gender and sexual behaviour and orientation, collect information on indicators of socioeconomic and educational status, residency/ migration status and marital status and link to HIV antibody results. This will measure HIV prevalence among sex workers, MSM, and heterosexual men and women self-identified as at risk of STIs attending sexual health clinics.

Conduct regular unlinked anonymous studies of HIV prevalence among IDUs.

Interpretations

The Ministry of Health and the AIDS Epidemiology Group need to consider this action given the availability of adequate resources.

Health researchers and funders of health research need to consider this action.

The Ministry of Health will continue conducting these studies. (See the Action on Hepatitis C Plan.)



Actions	Interpretations
<p>Introduce sentinel surveillance and serial testing among IDUs and people in prisons.</p>	<p>The Ministry of Health has established a memorandum of understanding with the Department of Corrections. The Ministry and the Department will need to consider this action in the context of their ongoing relationship. (See the Action on Hepatitis C Plan.)</p>
<p>Review data collected by the AIDS Epidemiology Group on people notified with AIDS and found diagnosed with HIV infection, taking into account UNAIDS recommendations and international experience.</p>	<p>The AIDS Epidemiology Group, in conjunction with other key stakeholders, needs to consider this action.</p>
<p>Regularly review progress in technology for laboratory testing to ensure appropriate tests are available for HIV diagnosis, management and care.</p>	<p>This action needs to be considered by the AIDS Epidemiology Group, the AIDS Medical and Technical Advisory Committee, laboratories, and DHBs.</p>
<p>Continue ongoing monitoring of the treatment received and outcome for New Zealand's HIV-positive population under active follow-up.</p>	<p>Health researchers and funders of health research could consider this action.</p>
<p>Continue ongoing monitoring of the completeness of AIDS notifications through linkage death registration information.</p>	<p>The AIDS Epidemiology Group currently undertakes this function.</p>
<p>Continue seeking information through the New Zealand Paediatric Surveillance Unit on women giving birth who are known to be infected with HIV.</p>	<p>The AIDS Epidemiology Group currently seeks this information.</p>





Objective 2:

Better understand the behaviours driving increases in HIV incidence and the trends in populations at highest risk of HIV infection

Actions

Conduct regular surveys on MSM's sexual behaviour.

Collect, as part of regular prevalence studies of Hepatitis C virus (HCV) and HIV among IDUs, information on sharing unclean injecting equipment and include indicators of socioeconomic status, residency/migration status and marital status.

Consider ways that representative information can be collected about the number of clients per week of sex workers and their use of condoms.

Consider incorporating HIV testing in any behavioural surveys of sex workers.

Consider ways that representative information from new immigrants from high-prevalence countries could be obtained to assess the ongoing risk in these communities.

Include, in the biannual sexual and reproductive health behaviour surveys, information on sexual behaviour particularly the proportion:

- reporting at least one non-regular sex partner in the last 12 months
- of those who have had sex with a non-regular partner in the last 12 months reporting using a condom the last time they had sex with such a partner.

Interpretations

A follow-up survey to the GAPSS survey is planned.

Regular prevalence studies of HCV/HIV among IDUs are planned and will seek this information. (See the Action on Hepatitis C Plan.)

Health researchers and their funders need to consider this action.

Health researchers and their funders need to consider this action.

Health researchers and their funders need to consider this action.

The Ministry of Health is developing a sexual and reproductive health behaviour survey and these questions will be incorporated.



Objective 3:

Ensure surveillance is flexible enough to move with the needs and state of the epidemic, and can increase understanding of what works and inform planning for prevention and care.

Actions	Interpretations
<p>Develop a process for prospectively reviewing the health outcomes of patients with HIV infection in New Zealand on a regular basis to provide a basis for evaluating their care and comparing it with the care provided to similar patients in other countries.</p>	<p>The Ministry of Health needs to consider the implications of this action given the availability of adequate resources.</p>
<p>Regularly review whether surveillance activities are flexible enough for the needs and state of the epidemic and can inform what works and prevention and care planning.</p>	<p>The Ministry of Health, in conjunction with key stakeholders such as the AIDS Epidemiology Group, will review HIV/AIDS surveillance from time to time.</p>





Appendix

Sector Reference Group Members

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Dr Nigel Dickson, FAFPHM	Epidemiologist, AIDS Epidemiology Group, Department of Preventive and Social Medicine, Dunedin School of Medicine
Alison Green	Manawhakahaere, Te Puawai Tapu
Dr Gill Greer	Executive Director, Family Planning Association of New Zealand
Catherine Healy	National Co-ordinator, New Zealand Prostitutes Collective
Tony Hughes, MSc (Hons)	Research Director New Zealand AIDS Foundation, Consultant to the AIDS Epidemiology Group
Dr Graham Mills	Infectious Diseases Physician, Waikato Hospital
Mr Matt Soeburg	Policy Analyst, New Zealand AIDS Foundation (former position), Policy Analyst, Auckland Regional Public Health Service (current position)
Dr Mark G. Thomas, MBChB, MD, FRACP	Associate Professor in Infectious Diseases, Auckland University, Member of the AIDS Medical and Technical Advisory Committee.





Glossary

CD4 cells	Helper T-cells that carry the CD4 surface antigen. CD4 cells are the primary target of HIV and CD4 cell numbers decline during HIV disease.
Primary prevention	Aims to prevent the initial occurrence of infection. Measures to achieve this include reducing or eliminating individual risk factors (through behaviour change or vaccination) as well as addressing environmental risk factors (such as causal factors at the level of society, for example, discrimination, inequality and lack of peer support). Primary prevention can involve the whole population and specific high-risk groups.
Men who have sex with men (MSM)	A term used in this document to refer to the population of males who have sex with other males, regardless of how they identify (eg, gay, bisexual, takataapui, heterosexual) or whether they have sex exclusively with males or males and females. By emphasising sexual behaviour over sexual identity, this definition directs attention towards the relevant characteristics of individuals who place themselves at risk of HIV transmission (unprotected anal sex between males), and away from characteristics that are not directly relevant for the transmission of HIV (sexual identity per se). Where it is thought useful, in some places a distinction is made between men who are exclusively homosexually active and men who have sex with both men and women (MSMW). The latter group is referred to as 'MSMW', as this again points to activity rather than the identity of such individuals.
Secondary prevention	Aims to identify infected individuals in an attempt to limit further transmission of infection to others, by education and reductions in infectivity through treatment. Secondary prevention can also directly benefit those diagnosed by reducing the severity of infection if effective treatments are available.
Serologic	Pertaining to serology, which is the scientific study of blood sera and their effects.





Seropositive

Individual has a serotype that suggests they have experienced infection in the past.

Seroprevalence

The proportion of a population that is seropositive.

Serotype

The range of antibodies possessed by an individual, usually based on sampling from blood, serum or saliva.

Voluntary counselling testing (VCT)

The process by which an individual undergoes counselling, and enabling him or her to make an informed choice about being tested for HIV. In recent years HIV testing, in combination with pre- and post-test counselling, has become increasingly important in national and international prevention and care efforts. Knowledge of serostatus through VCT can be a motivating force for HIV-positive people and HIV-negative people alike to adopt safer sexual behaviour, which enables seropositive people to prevent infecting their sexual partners and those who test seronegative to remain negative. This intervention also facilitates access to prevention services for seronegative people and is a key entry point to care and support services for those who are HIV infected. This includes access to interventions to reduce mother to child transmission (MTCT) of HIV, interventions to prevent opportunistic infections (for example, tuberculosis preventive therapy and prophylaxis for other infections) and other medical and supportive services that can help HIV-positive people to live longer and healthier lives.





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